



NOTICE OF APPEAL DECISION Healthy Way LA
Uphold or Modify Decision

Date

Name: ***(Insert Member Name or Representative):***

Member's Name:

Address:

City, State, Zip

Provider/Clinic/CAU:

HWLA Member Identification #:

DMH IS #:

Dear ***(Insert Member Name or Representative):***

A decision was made about your appeal of [***describe appeal***]. The decision was made on [***insert decision date***].

After careful review and investigation, our reviewer (***agrees with or has decided to change***) the original decision because [***insert a clear and concise explanation of the reason for the decision. The detail may contain a description of the UM criteria, benefit provision, or other resource used, including a citation of the specific regulations or authorization procedures supporting the action, and the clinical reasons for the decision regarding medical necessity***]

[Also use if modifying the decision]

Instead of the service requested, we are authorizing [***insert treatment or service***]. Authorization [***insert authorization number***] is effective [***insert effective dates***]. Please call [***insert provider/clinic name and telephone number***] to make an appointment for this service.

NOTE: If you cannot read or understand this letter, call Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TTD at (800) 735-2929.

If you do not agree with this decision, you have the following appeal rights:

1. You can ask for a State Fair Hearing. You must ask for a State Fair Hearing within **90 days** from the date on this letter.

You can ask to keep getting your services while waiting for the resolution of the State Fair Hearing if your appeal is about a decision by the Department of Mental Health (DMH) to terminate (end), suspend or reduce a course of treatment we had already approved, AND all of the following conditions are met:

- a. You asked for your appeal within 10 days from the date of the Notice of Action.
- b. You asked DMH to continue your services and those services were continued.
- c. The services were ordered by a Mental Health provider.
- d. The period covered by the original authorization has not ended.
- e. You asked for a State Fair Hearing within 10 days from the date of this letter and ask for services to continue until the State Fair Hearing decision is made.

Note: If the State Fair Hearing's decision agrees with the DMH's action, you may have to pay for the cost of the services you received while the appeal is going on.

To request a State Fair Hearing, call (800) 952-5253. If you have trouble hearing or speaking, you can call TTY/TDD at (800) 952-8349. You may also appeal by writing to:

**California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430**

Please send us a copy of your request for a State Fair Hearing if you file one.

This notice does not affect any other HWLA services.

Please call DMH Patients' Rights at (213) 738-4949 or TTY/TDD at (800) 735-2929 if you have any questions.

Sincerely,

(Name of Appeal Reviewer)

c: Requesting Provider/Clinic/CAU
DMH Patients' Rights